NATIONAL HEALTH COUNCIL

September 12, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program [CMS-1832-P]

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) proposed rule (CMS–1832–P) and associated proposals affecting other Medicare Part B payment policies.

Created by and for patient organizations over 100 years ago, the NHC convenes organizations from across the health ecosystem to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, comprehensive, accessible, and sustainable health care. Made up of more than 180 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses and organizations representing biopharmaceuticals, devices, diagnostics, generics, and payers.

In previous comment letters on the CY 2024 and CY 2025 PFS proposed rules, the NHC underscored the importance of avoiding abrupt payment changes that destabilize care delivery; of modernizing valuation methods to rely on empirical, auditable data; of expanding telehealth and supervision flexibilities with appropriate quality safeguards; and of ensuring that quality programs reflect outcomes and experiences that matter to patients. This letter builds on those positions while addressing new proposals for CY 2026.

General Comments

The CY 2026 PFS proposed rule contains numerous policy changes with significant implications for Medicare beneficiaries, clinicians, and other stakeholders. While the proposals range from payment mechanics to quality reporting, they should be considered in light of their combined impact on patient access, care quality, and the long-term sustainability of delivery systems. Notable elements include durable telehealth and virtual supervision flexibilities, new Advanced Primary Care Management (APCM) add-on codes, changes to practice expense (PE) methodology including use of Outpatient Prospective Payment System (OPPS) relativity for select technical services, a new efficiency adjustment to work Relative Value Units (RVUs), refinements to malpractice (MP) RVUs and geographic practice cost indices (GPCIs), and the proposed elimination of social risk-assessment codes.

The NHC evaluates all PFS proposals through a set of overarching priorities that reflect our mission to promote increased access to affordable, high-value, comprehensive, and sustainable health care. These priorities will guide the comments that follow:

- **Payment Stability and Predictability:** Abrupt or large negative shifts in reimbursement threaten practice sustainability and, by extension, patient access, especially in rural areas and other communities with limited provider availability.
- **Access to Care:** Coverage expansions should be paired with practical strategies that ensure beneficiaries can use new services, including improvements in infrastructure, technology, and workforce capacity.
- **Data-Driven and Transparent Valuation:** Valuation should rely on empirical, auditable, real-world evidence and site-appropriate adjustments, with transparent methods that account for differences across practice settings.
- **Integration of Physical, Behavioral, and Social Care:** Payment reforms should incentivize coordinated, team-based models that reflect the interaction between medical and behavioral health needs and address upstream drivers of health.
- **Support for Safety-Net Providers:** Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and other community-based providers require adequate payment and reduced administrative burden to remain viable.
- **Meaningful Patient Engagement:** Significant payment and delivery reforms should incorporate structured input from patients and caregivers, with CMS reporting how this feedback informs final policies.

The CY 2026 proposals make progress in several areas—such as modernizing telehealth policy and enabling virtual supervision of “incident to” services—while also raising concerns about the cumulative effects of layered payment changes (e.g., the efficiency adjustment and selected PE revisions) on practice viability and patient access. In addition, the proposal to eliminate social risk-assessment codes may hinder documentation and navigation of upstream needs that drive outcomes, particularly for clinicians who do not bill evaluation and management (E/M) codes.

The NHC appreciates steps that improve access and modernize valuation and encourages CMS to pair these changes with strong transparency and monitoring. Specifically, we urge CMS to phase in material negative impacts to avoid abrupt disruptions in care; publish disaggregated specialty- and service-level impact analyses;

retain and rename social risk-assessment services so they are appropriately documented and resourced; and strengthen post-implementation monitoring of access and quality, with mechanisms for mid-course corrections to ensure alignment with patient-centered outcomes and care-coordination goals.

PFS Payment Updates and Conversion Factors

For CY 2026, CMS proposes two separate PFS conversion factors, as required by statute. The conversion factor for qualifying Advanced Alternative Payment Models (APM) participants is set at $33.59, reflecting an increase of $1.24 (approximately +3.8%). For nonqualifying APM participants, CMS proposes a conversion factor of $33.42, an increase of $1.07 (approximately +3.3%). These updates are informed by statutory indexation under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the projected net effect of proposed changes in work RVUs, and adjustments to GPCIs and MP RVUs. While CMS notes that these conversion factor updates represent modest increases compared to the CY 2025 baseline of $32.35, the agency acknowledges that they remain below the actual rate of practice cost growth as measured by the Medicare Economic Index (MEI). This structural misalignment has become a persistent feature of physician payment policy, raising concerns about the sustainability of practice operations across diverse clinical settings.

Since the enactment of MACRA, annual conversion factor updates have generally been modest and, in many years, fully offset by budget-neutral adjustments triggered by RVU revaluations, coding changes, or policy shifts. In its prior comment letters, the NHC has consistently emphasized that inadequate updates reduce predictability for providers, erode payment adequacy once inflation is taken into account, and disproportionately affect specialties and practice types with limited flexibility to adapt to declining reimbursement or to shift services to other settings.[1] Although the CY 2026 conversion factors represent nominal increases, they are unlikely to provide meaningful relief for most clinicians once layered with the efficiency adjustment, practice expense (PE) methodology revisions, and other redistributive policy changes included in the proposed rule. Small and rural practices, which typically operate with narrow margins and limited capacity for cross-subsidization, may face heightened financial vulnerability.[2] Similarly, specialties that provide complex or resource-intensive services are at particular risk of reduced stability, with potential downstream effects on access for Medicare beneficiaries.[3]

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[1] National Health Council, "NHC Comments on Centers for Medicare & Medicaid Services (CMS) in Response to the Proposed Rule Medicare and Medicaid Programs: Calendar Year 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies," September 9, 2024, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-centers-for-medicare-medicaid-services-cms-in-response-to-the-proposed-rule-medicare-and-medicaid-programs-calendar-year-2025-payment-policies-under-the-physician-fee-schedule-and/.

[2] Ge Bai et al., “Varying Trends in the Financial Viability of US Rural Hospitals, 2011–17,” *Health Affairs* 39, no. 6 (2020): 942–48, https://doi.org/10.1377/hlthaff.2019.01545.

[3] Jeffrey Clemens and Joshua Gottlieb, “In the Shadow of a Giant: Medicare’s Influence on Private Physician Payments,” *Journal of Political Economy* 125, no. 1 (February 2017): 1–39, https://doi.org/10.1086/689772.

The ongoing divergence between conversion factor updates and the MEI further underscores the fragility of physician payment under the current framework.[4] Over time, this divergence diminishes the real value of payments and may compel providers to shift care toward hospital outpatient departments or other higher-cost settings. Such a trend not only increases expenditures for the Medicare program and beneficiaries but also threatens to undermine the availability of office-based services that are often more accessible and cost-effective.[5] To address these risks, the NHC recommends that CMS strengthen the transparency of its analyses by publishing disaggregated, specialty- and service-level impact tables that show the combined effects of the conversion factor updates, efficiency adjustments, PE revisions, and geographic cost index changes. Greater transparency will allow stakeholders to more accurately assess how proposed updates affect the stability of different specialties and practice settings and to anticipate any disproportionate impacts on access.

CMS should also consider implementing phased transitions where proposed payment reductions exceed sustainable thresholds. This would help protect small and rural practices while maintaining consistent patient access and would also reduce the risk of care shifting into higher-cost settings, thereby supporting both beneficiaries and the Medicare program. Phased implementation would mitigate sudden financial shocks and reduce the likelihood of practice closures or service discontinuations that could harm patient access. The NHC further urges CMS to work with Congress to pursue structural reforms that align future conversion factor updates with empirical measures of practice cost growth, such as the Medicare Economic Index. Absent such alignment, Medicare physician payments will continue to erode in real terms, threatening both access to care and long-term system sustainability. Finally, the NHC emphasizes the importance of prioritizing stability for patient-critical clinical services. Services such as complex evaluation and management visits, chronic care management, and behavioral health integration are central to the care of high-need Medicare beneficiaries. Ensuring payment adequacy for these foundational services is essential to sustaining access, supporting comprehensive care delivery, and protecting patient outcomes.

Efficiency Adjustment to Work RVUs and Time

For CY 2026, CMS proposes to implement a new –2.5 percent efficiency adjustment applied to work RVUs and intraservice time for non–time-based codes. The adjustment would be applied on a recurring three-year cycle and is intended to account for perceived efficiencies in physician work that may not be captured in existing valuation data. Importantly, CMS proposes to exclude certain categories of services from the adjustment, including E/M visits, care management, behavioral health services, and all services furnished through telehealth.

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[4] Kurt Strange, “The Problem of Fragmentation and the Need for Integrative Solutions.” *Annals of Family Medicine* 7, no. 2 (2009): 100–103. https://doi.org/10.1370/afm.971.

[5] Brady Post et al., “Hospital-Physician Integration and Medicare’s Site-Based Outpatient Payments,” *Health Services Research* 56, no. 1 (January 2021): 7–15, https://doi.org/10.1111/1475-6773.13613.

This proposal represents the first uniform downward adjustment to work RVUs. Historically, CMS has relied on targeted approaches such as identifying potentially misvalued codes and reviewing specialty-specific survey data to address discrepancies in valuation. The NHC has consistently cautioned against the use of broad, across-the-board adjustments that are not grounded in service-level data, noting that such policies risk undermining the stability of the PFS and introducing unintended distortions across specialties.[6] A blanket –2.5 percent reduction across non–time-based codes may not reflect meaningful differences in clinical practice, creating distortions that disadvantage certain specialties disproportionately. For example, specialties with limited numbers of billable codes may bear a larger share of the impact, even where there is no evidence of inefficiency. The proposed adjustment also risks further constraining the already narrow margins of community-based practices, particularly those dependent on procedural services.[7] In rural areas, where providers face recruitment challenges and limited patient volumes, even modest reductions in reimbursement could jeopardize the viability of essential services, forcing patients to travel long distances or delay care. Moreover, applying a uniform adjustment without service-specific evidence undermines the transparency and credibility of the valuation process, raising concerns about stakeholder confidence in the PFS.[8]

The NHC urges CMS to reconsider its approach. At minimum, the adjustment should be phased in gradually over multiple years, with safeguards to limit disproportionate specialty-level impacts. CMS should instead prioritize the development of empirical, service-specific efficiency factors grounded in real-world evidence and auditable data, an approach that would more accurately capture variations in clinical practice and to better reflect fairness across specialties. The agency should also commit to monitoring access implications on an ongoing basis, publishing data on utilization, beneficiary access, and practice closures or consolidations to identify unintended consequences. Finally, the NHC recommends establishing a formal mid-cycle review process to evaluate whether the adjustment achieves its intended goals without compromising patient access or care quality, and to make course corrections as needed.

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[6] National Health Council, “NHC Comments on the Proposed Rule: Medicare and Medicaid Programs; Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies,” September 11, 2023, https://nationalhealthcouncil.org/letters-comments/nhc-comments-on-2024-payment-policies-under-the-physician-fee-schedule/.

[7] Gopal Singh and Mohammad Siapush, “Widening Rural-Urban Disparities in All-Cause Mortality and Mortality from Major Causes of Death in the USA, 1969–2009.” *Journal of Urban Health* 91, no. 2 (2014): 272–292. https://doi.org/10.1007/s11524-013-9847-2.

[8] Committee on Improving Primary Care Valuation Decisions for the Physician Fee Schedule, National Academies of Sciences, Engineering, and Medicine, *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule* (Washington, DC: National Academies Press, 2024).

PE Methodology Updates

In the CY 2026 proposed rule, CMS declines to adopt new cost-share data from the American Medical Association (AMA) survey conducted in 2024 and 2025, citing concerns about data completeness and representativeness. Instead, CMS proposes several targeted adjustments, including recognition of the higher indirect costs incurred by office-based practices—particularly in specialties requiring significant infrastructure and administrative support—and the use of OPPS data to inform relativity for certain technical services such as radiation therapy and remote monitoring. These steps are intended to improve the accuracy of practice expense (PE) relative values while further evaluating the reliability of new survey data.

The NHC has consistently supported efforts to modernize PE valuation by incorporating empirical and auditable data sources, while cautioning against the direct application of hospital-based OPPS cost data to physician office settings without appropriate adjustments. Structural and scale differences between these environments make them non-interchangeable, and unadjusted application could distort valuations.[9] The NHC has emphasized in prior letters that methodological accuracy must be balanced with payment stability, particularly for practices serving vulnerable or resource-limited populations.[10]

The proposed reliance on OPPS data to establish relativity for select technical services requires particular scrutiny. Hospital outpatient departments and physician offices operate with markedly different staffing models, overhead structures, and economies of scale. Without site-specific adjustments, applying OPPS data directly could undervalue services furnished in office-based settings, creating financial pressures that shift care toward higher-cost hospital environments.[11] Such a shift would increase costs for both Medicare and beneficiaries and could reduce the availability of community-based services, especially in rural areas where office-based practices are often the primary source of timely care.

The NHC recommends that CMS enhance transparency by publishing detailed explanations of how OPPS data are mapped into PFS PE inputs and adopting site-neutral adjustment factors that reflect structural differences between care settings. Pilot testing of new methodologies on a limited basis should precede broad application, allowing early identification of valuation distortions or access concerns. Stakeholder engagement—particularly from rural providers, safety-net practices, and patient organizations—should be central to this process. Finally, CMS should clarify the criteria and timeline for incorporating updated AMA survey data once quality and

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[9] RAND Corporation, *Practice Expense Methodology and Data Collection Research and Analysis*, RR-2166-CMS (Santa Monica, CA: RAND Corporation, 2018), https://www.rand.org/pubs/research_reports/RR2166.html.

[10] NHC, “NHC Comments on CY 2025 PFS Proposed Rule.”

[11] Bipartisan Policy Center, "Paying the 2025 Tax Bill: Site Neutrality in Medicare Payment," April 11, 2025, https://bipartisanpolicy.org/explainer/paying-the-2025-tax-bill-site-neutrality-in-medicare-payment/.

representativeness issues are resolved. A transparent and empirically grounded approach will improve confidence in the long-term sustainability of PE valuation and ensure alignment with real-world resource use.

MP RVUs and Geographic Practice Cost Indices (GPCIs)

For CY 2026, CMS proposes routine updates to MP RVUs and geographic practice cost indices (GPCIs). These updates incorporate MP premium data from 2023 filings and revised geographic indices for wages, practice expenses, and MP costs. As required by statute, the adjustments will be implemented in a budget-neutral manner, redistributing payments across specialties and localities. Key elements include updated MP premium data by specialty, application of revised geographic adjustments to all three PFS components, and redistributive effects that will increase payments in some areas while decreasing them in others.

Although the NHC has not previously focused on the technical mechanics of MP RVU valuation, we have consistently emphasized that geographic adjustments meaningfully influence provider availability and patient access. The NHC has supported CMS' efforts to ensure that geographic cost data are accurate and representative, while also urging the agency to monitor for unintended consequences in rural communities where even small reductions can disrupt the availability of care.[12]

The NHC is particularly concerned that the proposed updates may disproportionately affect high-liability specialties such as obstetrics/gynecology and neurosurgery.[13] Practices in these fields already face high MP premiums, and further downward adjustments through geographic indices could discourage providers from maintaining services in communities with limited alternatives. These risks are most acute in rural areas, where the withdrawal of a single specialist can eliminate local access to critical care.[14] Moreover, when layered with the efficiency adjustment and ongoing PE methodology revisions, the redistributive nature of the GPCI updates could compound payment reductions in certain specialties or regions, placing additional strain on financially vulnerable practices.

To mitigate these risks, the NHC recommends that CMS strengthen transparency by publishing specialty- and locality-level impact tables so stakeholders can assess provider sustainability and patient access. Where redistributive effects are especially severe, CMS should consider transitional adjustments, particularly in rural areas and Health Professional Shortage Areas where losses exceeding three percent could destabilize care availability. The NHC also urges CMS to monitor real-world access

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[12] NHC, "NHC Comments on CY 2024 PFS Proposed Rule."

[13] Aaron Carroll and Jennifer Buddenbaum, "High- and Low-Risk Specialties' Experience with the U.S. Medical Malpractice System," *BMC Health Services Research* 13, no. 465 (2013), https://doi.org/10.1186/1472-6963-13-465.

[14] Sterling Ransone Jr., "How Medicare's broken pay system harms rural patients, physicians," *AMA News Wire*, January 27, 2025.

closely following implementation, with special attention to high-liability specialties and rural communities. Finally, CMS should explore smoothing mechanisms such as multi-year averaging of MP premiums and geographic index data to reduce volatility in payment updates, promote stability for providers, and safeguard patient access.

Telehealth and Virtual Supervision Policies

For CY 2026, CMS proposes several meaningful upgrades to telehealth and virtual supervision, including eliminating "provisional" and "permanent" designations on the Medicare Telehealth Services List; permanently removing visit-frequency limits for inpatient, skilled nursing facility, and critical care telehealth; permitting virtual direct supervision via real-time audio-video for "incident to," diagnostic testing, and rehabilitation services (excluding surgical global packages); and restoring pre-COVID-19 public health emergency (PHE) teaching-physician presence standards in metropolitan areas while maintaining virtual flexibilities in rural and resource-limited settings.

Since the onset of the PHE, the NHC has supported telehealth as a tool to ensure continuity of care, reduce geographic and transportation barriers, and support management of chronic and complex conditions, and in prior comment letters, the NHC has emphasized eliminating arbitrary visit frequency limits, supporting the use of virtual direct supervision where clinically appropriate, and ensuring payment parity for telehealth services equivalent in value to in-person care.[15]

The NHC views CMS' proposals to make permanent several flexibilities as constructive steps that will benefit patients and providers. Permanently removing frequency limits, modernizing the Telehealth Services List framework, and allowing virtual direct supervision of "incident to" services are changes that preserve access, reduce travel burdens, and extend specialty expertise, particularly for patients with mobility, transportation, or caregiver constraints and for behavioral health services that rely on flexible models of supervision. However, access challenges remain for many beneficiaries who lack affordable broadband, reliable devices, or the digital literacy needed to fully engage in telehealth.[16,17] While we recognize that some stakeholders may argue against exempting certain services from broader adjustments or flexibilities on the grounds of budget neutrality or fairness across specialties, the NHC believes these services are foundational to patient care and central to supporting the management of chronic and complex conditions. Treating them differently is justified to

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[15] NHC, "NHC Comments on CY 2024 PFS Proposed Rule" and "NHC Comments on CY 2025 PFS Proposed Rule."

[16] Lisa Koonin et al., "Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020," *MMWR. Morbidity and Mortality Weekly Report* 69, no. 43 (2020): 1595–99, https://doi.org/10.15585/mmwr.mm6943a3.

[17] Sadiq Patel et al., "Trends in Outpatient Care Delivery and Telemedicine During the COVID-19 Pandemic in the US." *JAMA Internal Medicine* 181, no. 3 (2021): 388–391. https://doi.org/10.1001/jamainternmed.2020.5928.

protect continuity, prevent disruptions in behavioral health access, and ensure patients with the greatest needs do not face new barriers as CMS implements efficiency measures elsewhere in the PFS.

To maximize these gains, we recommend a focused implementation agenda rather than additional restrictions: 1) sustain payment parity where clinical value is equivalent; 2) strengthen quality guardrails and publish practical guidance for virtual supervision; 3) continue rolling additions to the Telehealth Services List as evidence evolves; and 4) partner with federal and state entities to close remaining digital access gaps (affordable broadband, devices, and basic digital literacy), so beneficiaries can fully utilize covered services without new barriers.

The NHC supports and seeks to build on the CY 2026 telehealth and virtual supervision proposals and urges CMS to do so in several ways. CMS should strengthen its monitoring of telehealth utilization and outcomes, with particular attention to differences by geography and local availability of services, to ensure that access gains are broadly realized. The agency should also retain the ability to add new services to the Medicare Telehealth Services List on a rolling basis throughout the year, rather than limiting updates to the annual rulemaking cycle, in order to remain responsive to evolving clinical evidence and patient needs. In addition, CMS should establish and disseminate clear quality safeguards for services furnished under virtual supervision, ensuring that patients continue to receive safe and effective care regardless of modality. Addressing persistent infrastructure gaps will also be essential. CMS should collaborate with the Federal Communications Commission, the Department of Agriculture, and other federal and state partners to expand broadband availability and ensure that beneficiaries have access to the devices and technical support needed to engage in telehealth effectively. Finally, the NHC recommends that CMS publish annual reports evaluating the impact of telehealth expansions on patient access, including metrics such as travel burden, wait times, and missed appointment rates. Such transparency will enable stakeholders to assess progress, identify remaining gaps, and refine policies to ensure that telehealth fulfills its promise of expanding access to high-quality, patient-centered care.[18]

Evaluation & Management, Care Management, and Behavioral Health

In the CY 2026 proposed rule, CMS outlines several updates related to E/M, care management, and behavioral health services. These include excluding E/M, care management, behavioral health, and telehealth codes from the proposed –2.5 percent efficiency adjustment; introducing new Advanced Primary Care Management (APCM) add-on codes for clinicians managing patients with multiple chronic and complex conditions; expanding coverage of Digital Mental Health Treatment (DMHT) services by adding ADHD to the list of eligible conditions while seeking comment on additional diagnoses; and eliminating the current social risk-assessment codes.

[18] Annette Totten et al., Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016 Jun. (Technical Briefs, No. 26.) Available from: https://www.ncbi.nlm.nih.gov/books/NBK379320/.

The NHC has consistently emphasized the importance of stable payment for E/M and care management services to support the longitudinal management of chronic illness and prevent avoidable hospitalizations.[19] We have also supported the introduction of add-on codes to recognize the resources required for comprehensive care coordination and the expansion of behavioral health coverage as integral to whole-person care.[20] In previous letters, the NHC has underscored the importance of eliminating barriers such as cost sharing for preventive services, maintaining adequate reimbursement for safety-net providers, and ensuring that digital mental health solutions are implemented in ways that address infrastructure and literacy barriers.[21]

The NHC commends CMS for excluding E/M, care management, behavioral health, and telehealth services from the efficiency adjustment, recognizing the foundational role these services play in patient care.[22] We also support the introduction of APCM add-on codes as an important step toward acknowledging the complexity and interdisciplinary coordination involved in managing patients with multiple chronic conditions. However, the NHC urges CMS to determine that APCM services are preventive and therefore not subject to cost sharing, consistent with CMS' proposal to integrate depression screening and the Annual Wellness Visit into APCM. Aligning APCM with preventive status will reduce barriers to uptake and ensure that patients benefit from longitudinal, team-based care.

The NHC is concerned about CMS' proposal to eliminate social risk-assessment codes. These services are not fully captured within E/M documentation, and many behavioral health and allied professionals who address housing, food security, transportation, and caregiver needs do not bill E/M codes. We therefore urge CMS to retain these services under dedicated codes and to rename them "Upstream Drivers of Health (UDH) Assessment and Navigation."[23] Such codes will help identify patient needs, support navigation and linkage to resources, and enable accurate measurement of how upstream drivers affect utilization and outcomes. Removing them would risk under-documenting and under-resourcing services that are essential to whole-person care.

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[19] NHC, "NHC Comments on CY 2024 PFS Proposed Rule" and "NHC Comments on CY 2025 PFS Proposed Rule."

[20] NHC, "NHC Comments on CY 2025 PFS Proposed Rule."

[21] NHC, "NHC Comments on CY 2024 PFS Proposed Rule" and "NHC Comments on CY 2025 PFS Proposed Rule."

[22] Joseph Firth et al., "The Lancet Psychiatry Commission: A Blueprint for Protecting Physical Health in People with Mental Illness." *The Lancet Psychiatry* 6, no. 8 (2019): 675–712. https://doi.org/10.1016/S2215-0366(19)30132-4.

[23] Nazleen Bharmal et al., *Understanding the Upstream Social Determinants of Health,* RAND Health Working Paper WR-1096-RC (Santa Monica, CA: Rand Corporation, 2015), https://www.rand.org/content/dam/rand/pubs/working_papers/WR1000/WR1096/RAND_WR1096.pdf.

The expansion of DMHT coverage represents a promising development, particularly in the face of workforce shortages in mental health.[24] However, without strategies to address persistent broadband, device, and digital literacy barriers, expanded coverage will not achieve its intended impact. CMS must ensure that technology-enabled services are implemented in ways that promote access across the full Medicare population.

To ensure that these proposals achieve their intended goals, the NHC recommends that CMS clarify that APCM services furnished with depression screening or the Annual Wellness Visit are preventive and should not be subject to cost sharing, and that CMS establish clear criteria for when standalone APCM services qualify as preventive. The agency should also streamline documentation requirements for APCM and behavioral health integration codes so that additional payment is accessible to clinicians and not undermined by administrative burden. In addition, CMS should adopt targeted strategies to support broader adoption of DMHT, including investments in devices, broadband access, and digital literacy programs, particularly in areas where beneficiaries face the greatest barriers. The NHC further recommends that CMS retain and rename the eliminated risk-assessment codes, provide clear cross-setting coding guidance for non-E/M billing providers, and encourage their consistent use alongside Z-code documentation. Finally, CMS should monitor and publicly report outcomes associated with APCM, behavioral health integration, and DMHT utilization, with results disaggregated by geography and beneficiary access patterns, and incorporate patient and caregiver perspectives into future refinements of these policies to ensure that they remain responsive to the needs of Medicare beneficiaries.

Global Surgical Package Data Collection

For CY 2026, CMS proposes to continue and expand its data collection initiative designed to assess whether the number and duration of postoperative visits included in global surgical packages accurately reflect actual clinical practice. Under the proposal, practitioners in all states, not just those included in prior pilots, would be required to report the number of postoperative visits furnished for select 10-day and 90-day global surgical codes. CMS also proposes to expand the list of codes subject to reporting, focusing on high-volume and high-cost procedures, and to use these data to inform potential revaluation of global surgical package RVUs in future rulemaking. CMS highlights that previous studies, including those conducted by the Office of Inspector General and the Government Accountability Office, found that the number of postoperative visits included in global packages often exceeds the number of visits

[24] David Mohr et al., “Three Problems with Current Digital Mental Health Research … and Three Things We Can Do About Them.” *Psychiatric Services* 68, no. 5 (2017): 427–429. https://doi.org/10.1176/appi.ps.201600541.

actually provided.[25,26] CMS interprets these findings as suggesting potential overvaluation of certain surgical codes under current methodologies.

The NHC has not previously engaged in the technical details of surgical code valuation but has consistently emphasized the importance of ensuring accurate RVU assignment based on real-world service delivery. In previous comment letters, the NHC has stressed the need to avoid abrupt payment changes that might disrupt access to postoperative care, while also urging CMS to ensure that any revisions to postoperative visit expectations do not undermine recovery and patient safety. In its CY 2025 comments, the NHC supported expanding data collection beyond initial pilot states, provided that the reporting burden remained reasonable and that data use was transparent and carefully interpreted.[27]

The NHC recognizes that expanding postoperative data collection nationwide should yield more robust and geographically diverse information, strengthening the empirical foundation for any future adjustments. However, differences in practice patterns across specialties, care settings, and patient populations mean that CMS must interpret the data with caution to avoid overgeneralizing findings. It is essential that this effort be aligned with principles of real-world evidence and empirical, auditable data to enhance both accuracy and credibility.[28] The NHC is concerned about the potential for unintended consequences if postoperative visit expectations are reduced too aggressively. Advances in surgical technique and recovery protocols may justifiably reduce visit needs for some patients, but many populations—including older adults, individuals with multiple chronic conditions, and those with limited family or social support—require more intensive follow-up than statistical averages suggest. Payment policies that do not reflect this variation could jeopardize recovery and increase risks of complications or readmissions. Administrative burden is another critical concern. Data collection requirements must be integrated into existing claims submission and reporting systems wherever possible, so that the effort to generate accurate valuation data does not divert limited clinical resources away from patient care.

The NHC recommends that CMS ensure broad specialty engagement in designing and refining data collection tools, with particular input from high-complexity surgical specialties where follow-up care needs are more variable. Data should be stratified by patient complexity to avoid setting visit expectations based solely on median or mean

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[25] US Department of Health and Human Services, Office of Inspector General, "CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries" (report A-05-20-00021, July 1, 2025).

[26] US Department of Health and Human Services, Office of Inspector General, "Musculoskeletal Global Surgery Fees Often Did Not Reflect the Number of Evaluation and Management Services Provided" (report A-05-12-00053, May 1, 2012).

[27] NHC, “NHC Comments on CY 2025 PFS Proposed Rule.”

[28] National Academies of Sciences, Engineering, and Medicine, *Integrating Social Care into the Delivery of Health Care: Moving Upstream to Improve the Nation’s Health* (Washington, DC: National Academies Press, 2019), https://doi.org/10.17226/25467.

patterns, which could disadvantage patients requiring additional care.[29] Payment adequacy must be preserved for cases where higher-than-average postoperative care is clinically necessary. CMS should integrate data collection into existing claims or quality reporting workflows in order to minimize provider burden, and it should commit to publishing findings in a transparent manner, with clear explanations of how the data will inform any future revaluations of surgical codes. Finally, the NHC urges CMS to explicitly align this initiative with principles of real-world evidence and to ensure that data used for valuation are empirical, auditable, and representative. Such steps will strengthen stakeholder confidence in the fairness of the process and safeguard patient access to appropriate postoperative care.

Remote Monitoring and Radiation Therapy PE Updates

In the CY 2026 proposed rule, CMS introduces several PE updates with direct implications for both technology-enabled care and cancer treatment. For remote monitoring services, including remote physiological monitoring (RPM) and remote therapeutic monitoring (RTM), CMS proposes to update labor and equipment pricing and to use data from the OPPS to establish relativity across service categories. For radiation therapy, CMS proposes to apply OPPS relativity to select technical services and to update the pricing of capital equipment used in treatment delivery, citing the need to better align resource inputs with current market costs.

The NHC has consistently supported policies that promote the adoption of technology-enabled care such as RPM and RTM, recognizing their potential to enhance disease management, improve patient engagement, and prevent avoidable hospitalizations.[30] However, the NHC has also repeatedly cautioned against direct reliance on OPPS data for PE valuation without adjustments, as hospital outpatient departments and physician offices operate under fundamentally different cost structures.[31] With respect to radiation therapy, the NHC has emphasized the importance of sustaining access to community-based oncology and radiation treatment centers, particularly in rural areas, while ensuring that equipment pricing remains aligned with current costs.[32]

The NHC acknowledges that the proposed labor and equipment pricing updates for RPM and RTM represent an important step toward ensuring payment adequacy for these services. However, reliance on OPPS relativity to establish PE values raises significant concerns.[33] Physician offices and community-based practices typically

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[29] Anup Das et al., "Claims-Based Reporting of Post-Operative Visits for Procedures with 10- or 90-Day Global Periods: Updated Results Using Calendar Year 2019 Data," *Journal of General Internal Medicine* 37, no. 12 (December 2022): 3087–94, https://pmc.ncbi.nlm.nih.gov/articles/PMC9519106/.

[30] NHC, "NHC Comments on CY 2024 PFS Proposed Rule."

[31] NHC, "NHC Comments on CY 2025 PFS Proposed Rule."

[32] NHC, "NHC Comments on CY 2024 PFS Proposed Rule" and "NHC Comments on CY 2025 PFS Proposed Rule."

operate with smaller patient volumes, higher per-unit administrative costs, and less favorable economies of scale than hospital outpatient departments.[34] Without site-specific adjustments, the use of OPPS data risks systematically undervaluing office-based delivery of remote monitoring services, which could hinder adoption and limit access for patients who would benefit most.[35] For radiation oncology, updating the pricing of capital equipment is a positive development that more accurately reflects current market conditions. Nonetheless, the proposed application of OPPS relativity to technical services could jeopardize the financial sustainability of freestanding clinics, which play a critical role in providing timely access to cancer care outside of hospital settings.[36] Payment reductions in this area could accelerate consolidation into hospital outpatient departments, raising costs for both the Medicare program and beneficiaries, and reducing local access for patients in rural or underserved communities.[37]

The NHC recommends that CMS incorporate site-neutral adjustment factors when using OPPS data to establish PE relativity, in order to account for the structural differences between physician offices and hospital outpatient departments. CMS should also publish detailed service-level impact analyses so that stakeholders can fully understand the implications of the proposed updates for different specialties and practice settings. In addition, CMS should prioritize the preservation of access to community-based oncology and radiation treatment services, which are essential for many Medicare beneficiaries, particularly in rural areas. The agency should establish formal feedback loops with patients, providers, and stakeholders to monitor the effects of these policy changes on access, quality, and care costs. Finally, CMS should continue to support broad-based adoption of RPM and RTM services by pairing payment policies with targeted outreach, technical assistance, and infrastructure support to ensure that patients in underserved communities are able to benefit fully from technology-enabled care.

Part B Drugs, Biologicals, and Inflation Reduction Act (IRA) Implementation

For CY 2026, CMS proposes updates affecting Medicare Part B drugs and biologicals, including continuation of the Average Sales Price (ASP) +6 percent methodology, the

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[33] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC, June 2022. https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_Ch6_MedPAC_Report_to_Congress_SEC.pdf.

[34] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*.

[35] Leemore Dafny et al., "What Happens When Private Equity Firms Sell Medical Practices?" Working Knowledge, Harvard Business School, August 26, 2025. https://www.library.hbs.edu/working-knowledge/what-happens-when-private-equity-firms-sell-medical-practices.

[36] Sifan Grace Lu, Kunal Sindhu, and Jared Rowley, “Changes in Employment and Practice Locations Among Radiation Oncologists: 2015–2023,” *International Journal of Radiation Oncology, Biology, Physics* 122, no. 5 (August 1, 2025): 1095–1101, https://doi.org/10.1016/j.ijrobp.2025.02.036.

[37] Lu et al., “Changes in Employment and Practice Locations Among Radiation Oncologists.”

temporary ASP +8 percent add-on for biosimilars, implementation of the IRA's inflation-rebate provisions, and steps to expedite coding and payment for newly approved therapies. Each of these proposals has significant implications for patients who depend on timely, affordable access to physician-administered therapies. Notably, CMS states that for Part B drugs selected for IRA negotiation, the maximum fair price (MFP) for the drug will factor into the drug's ASP.

The NHC supports efforts that reduce beneficiary out-of-pocket costs, encourage appropriate biosimilar adoption, and ensure that patients with serious and rare conditions can access innovative therapies without delay.[38,39] However, the proposed incorporation of MFPs into ASP calculations for selected Part B drugs introduces risks that could directly affect patient access and continuity of care. Because ASP is used broadly across Medicare Advantage and commercial contracts, sustained downward pressure on ASP could ripple across payers, with add-on payments for Part B drugs projected to decline by as much as fifty percent for affected products, with significant reductions in overall reimbursement over time.[40,41,42,43] Reductions in ASP-based reimbursement could also accelerate practice consolidation and diminish the availability of infusion and injection services in community settings, particularly in oncology and immunology, resulting in increased travel requirements, longer wait times, and greater reliance on hospital outpatient departments, which are often less accessible and more costly.[44] These risks are compounded by CMS' indication that it may discontinue publishing ASP values exclusive of MFP-discounted units. Without that benchmark, payers could default to MFP itself as a reimbursement standard, further compressing

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[38] National Health Council, "NHC Submits Comments on CMS Draft Guidance for IPAY 2028," June 26, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-submits-comments-on-cms-draft-guidance-for-ipay-2028/.

[39] NHC, "NHC Comments on IPAY 2028 Draft Guidance."

[40] Milena Sullivan et al., "Commercial Spillover Impact of Part B Negotiations on Physicians," *Avalere Health*, September 16, 2024, https://advisory.avalerehealth.com/insights/commercial-spillover-impact-of-part-b-negotiations-on-physicians.

[41] Milena Sullivan et al., "Estimating the Spillover Impact of IRA Part B Negotiation," *Avalere Health,* January 27, 2025, https://advisory.avalerehealth.com/insights/estimating-the-spillover-impact-of-ira-part-b-negotiation.

[42] Michelle Robb, Katherine Holcomb, and Ivanna Ulin, *Impact of Inflation Reduction Act on Part B Provider Payment and Patient Access to Care* (Milliman, May 2025), https://www.milliman.com/en/insight/ira-impact-on-part-b-provider-payments.

[43] Avalere Health, "Provider Perspectives on Medicare Drug Price Negotiation: Implications for Part B Beneficiary Access, Practice Operations, and Reimbursement," *Avalere Health Advisory,* September 2025, https://advisory.avalerehealth.com/wp-content/uploads/2025/09/White-Paper_Provider-Perspectives-on-Medicare-Drug-Price-Negotiation-Implications-for-Part-B-Beneficiary-Access-Practice-Operations-and-Reimbursement2.pdf.

[44] Avalere Health, "IRA Medicare Part B Negotiation Shifts Financial Risk to Physicians." *Avalere Health Advisory*, November 2022. https://advisory.avalerehealth.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians.

rates and creating volatility across markets.[45] To preserve stability and protect patients, the NHC urges CMS to clarify that MFPs are not intended to function as default payment limits outside of Medicare fee-for-service and that ASP should remain the benchmark for multipayer contracts. CMS should also continue to publish ASP values exclusive of MFP units, delay implementation to allow for further stakeholder input, and phase in any changes with robust monitoring of patient-level indicators such as travel distances, continuity of infusion services, and treatment delays. Without complementary reforms, the ASP model may also continue to allow unsustainable pricing dynamics, particularly in specialty markets.[46]

In addition to these proposals affecting ASP and MFP, CMS seeks to encourage greater biosimilar adoption as a pathway to expanding patient access and lowering costs. The continuation of the biosimilar add-on is a constructive step, but successful adoption will depend on patient and provider confidence. The extension of the ASP plus eight percent add-on for biosimilars may encourage greater uptake, but this will ultimately rely on trust, education, and evidence of real-world effectiveness.[47] The NHC notes that incentives must be paired with investments in communication and education to avoid patient confusion or inappropriate non-medical switching. Periodic reevaluation of the add-on, combined with monitoring of patient experiences, will help ensure that the policy is meeting its intended goals.

The operationalization of IRA inflation rebates represents one of the most consequential aspects of the CY 2026 proposals. Properly implemented, these rebates have the potential to deliver significant out-of-pocket relief to Medicare beneficiaries, but their effectiveness will depend on CMS' ability to ensure transparency in rebate calculations and to communicate changes clearly to patients, providers, and pharmacies. Unclear or inconsistent guidance could delay reimbursement, create cash-flow challenges for providers, and erode patient trust in the program.[48] To strengthen implementation, CMS should publish quarterly rebate lists in plain language and include specific coinsurance amounts so that beneficiaries can anticipate the financial impact of inflation protections. Coding and payment for new therapies must also be established in a timely and predictable manner, particularly for treatments addressing rare or life-threatening conditions where delays have significant consequences. Without timely coding and payment, access to novel therapies can be delayed, undermining the benefits of innovation and creating inequities in care. CMS should closely monitor the effects of

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[45] Avalere Health, "Provider Perspectives on Medicare Drug Price Negotiation: Implications for Part B Beneficiary Access, Practice Operations, and Reimbursement."

[46] Sean Sullivan et al., "Stakeholder Perspectives on the Sustainability of the United States Biosimilars Market." *Journal of Managed Care & Specialty Pharmacy* 30, no. 10 (July 16, 2024): 1050–59. https://doi.org/10.18553/jmcp.2024.30.10.1050.

[47] Sullivan et al., "Stakeholder Perspectives on the Sustainability of the United States Biosimilars Market."

[48] Sharon Phares et al., "Managing the Challenges of Paying for Gene Therapy: Strategies for Market Action and Policy Reform in the United States," *Journal of Comparative Effectiveness Research* 13, no. 12 (November 14, 2024): e240118, https://doi.org/10.57264/cer-2024-0118.

biosimilar adoption and rebate implementation to ensure that all beneficiaries—including those in rural areas, patients with limited provider options, and individuals with rare conditions—continue to have reliable access to needed therapies. Just as importantly, prescribing decisions must remain grounded in clinical judgment so that patients are not subject to changes in therapy driven solely by cost considerations. Protecting clinical decision-making in this way is essential to maintaining patient safety, fostering confidence in biosimilars, and sustaining trust in the IRA's negotiated drug provisions.

Medicare Shared Savings Program (MSSP) and Specialty Care Models

In the CY 2026 proposed rule, CMS outlines several refinements to the MSSP and advances work on developing specialty care models. For the MSSP, CMS proposes to modify benchmarks by blending historical expenditure trends with national growth factors, with the goal of improving predictability and reducing volatility for Accountable Care Organizations (ACOs). The agency also proposes to expand attribution criteria to include nurse practitioners (NPs) and physician assistants (PAs), thereby recognizing the increasing role of advanced practice providers in Medicare beneficiary care. In addition, CMS proposes to incorporate social risk factors into risk adjustment methodologies to better account for the needs of populations facing systemic barriers to health. Beyond the MSSP, CMS notes that it is developing specialty-focused value-based models in oncology, cardiology, and nephrology. These models are intended to address high-cost and high-complexity conditions by incentivizing more coordinated and integrated specialty care delivery.

The NHC has consistently supported value-based payment models as mechanisms to align provider incentives with patient-centered outcomes, provided that such models adequately account for patient complexity, do not create access barriers, and embed mechanisms for patient and caregiver engagement. The NHC has previously emphasized the importance of robust risk adjustment, inclusive attribution rules that reflect the full spectrum of clinicians providing care to Medicare beneficiaries, and the integration of patient-reported outcome measures (PROMs) to ensure that models are responsive to what matters most to patients.[49]

The NHC views the proposed refinements to MSSP benchmarking as a constructive step toward stabilizing participation and improving alignment between local and national expenditure trends. This approach could reduce the volatility that has discouraged some ACOs from entering or remaining in the program. Expanding attribution to include NPs and PAs is similarly positive, as it reflects the central role these clinicians play in delivering primary care services to Medicare beneficiaries. However, attribution refinements must be implemented carefully to ensure that patients with complex or multi-specialty care needs are not misaligned or excluded from ACO accountability structures. The inclusion of social risk factors in risk adjustment represents an important acknowledgement of the varied circumstances that influence beneficiary health outcomes.[50] At the same time, the design of such adjustments must balance fairness

[49] NHC, "NHC Comments on CY 2025 PFS Proposed Rule."

with accountability, ensuring that payments reflect the needs of beneficiaries with greater health and support requirements while also maintaining strong incentives for providers to improve care quality and efficiency.[51] To be effective, these adjustments should be accompanied by careful monitoring and transparent reporting that demonstrate how they are functioning in practice.[52] The specialty models under development hold significant promise for addressing the needs of beneficiaries with high-cost conditions such as cancer, cardiovascular disease, and chronic kidney disease. However, these models must be designed to complement rather than fragment primary care. Without clear requirements for integration between specialty and primary care, there is a risk that value-based specialty models could operate in silos, undermining coordination and continuity for patients who often rely on multiple clinicians across disciplines.

The NHC recommends that CMS ensure attribution policies are inclusive of all relevant providers, particularly for patients who receive a significant portion of their care through specialty practices. Attribution rules should recognize the care patterns of specialty-driven patients to avoid gaps in accountability. CMS should also prioritize the development and integration of PROMs into both MSSP and specialty model evaluations. PROMs, designed with direct patient input, are essential to ensuring that value-based models are aligned with patient goals and preferences.[53] In addition, specialty models must be required to demonstrate integration with primary care providers and ACOs to ensure that care delivery remains coordinated and patient-centered. CMS should publish transparent evaluation metrics for both MSSP refinements and specialty models, including quality, cost, and patient experience outcomes. Finally, the NHC encourages CMS to employ flexible payment methodologies that blend episodic and longitudinal incentives. Such blended models are better suited to reflect the realities of caring for patients with complex and chronic conditions, where both acute episodes and long-term management are critical to achieving optimal outcomes.

RHCs and FQHCs

For CY 2026, CMS proposes several updates relevant to RHCs and FQHCs. The agency proposes to permanently extend telehealth coverage for these providers,

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[50] Jonathan Jaffery and Dana Gelb Safran, “Addressing Social Risk Factors in Value-Based Payment: Adjusting Payment Not Performance to Optimize Outcomes and Fairness,” *Health Affairs Forefront*, April 19, 2021, https://doi.org/10.1377/forefront.20210414.379479.

[51] Michael Zhu et al., *The Future of Risk Adjustment: Supporting Equitable, Comprehensive Health Care* (Durham, NC: Duke University Margolis Center for Health Policy, June 29, 2022), https://healthpolicy.duke.edu/sites/default/files/2022-06/Margolis%20Future%20Risk%20Adjustment%20Paper%20v3_0.pdf.

[52] Hannah Crook et al., *How Are Payment Reforms Addressing Social Determinants of Health? Policy Implications and Next Steps* (New York: Milbank Memorial Fund, February 2021).

[53] Danielle Lavallee et al., “Incorporating Patient-Reported Outcomes into Health Care to Engage Patients and Enhance Care,” *Health Affairs* 35, no. 4 (April 2016): 575–582, https://doi.org/10.1377/hlthaff.2015.1362.

ensuring that services furnished via telehealth remain reimbursable under the RHC all-inclusive rate (AIR) methodology and the FQHC prospective payment system (PPS). CMS also proposes to apply MEI updates to the AIR and PPS base rates to reflect changes in practice costs. In addition, CMS proposes to expand behavioral health services furnished in RHCs and FQHCs by recognizing licensed marriage and family therapists (MFTs) and mental health counselors (MHCs) as billable providers. Finally, CMS seeks public comment on approaches to reduce administrative reporting burden for these providers, many of which face overlapping requirements across multiple Medicare and Medicaid programs.

The NHC has consistently prioritized the sustainability of safety-net providers, recognizing their critical role in serving Medicare beneficiaries in rural and underserved communities. Previously, the NHC has supported making telehealth flexibilities permanent for RHCs and FQHCs, noting that these providers often represent the only local source of care for patients with complex chronic conditions.[54] The NHC has also endorsed expansion of behavioral health services in these settings, while emphasizing the need for targeted efforts to address persistent workforce shortages.[55]

The NHC strongly supports the proposal to make telehealth coverage permanent for RHCs and FQHCs. Telehealth has become indispensable in expanding access to behavioral health and chronic disease management in rural communities, where geographic isolation and transportation barriers often impede in-person visits.[56] Maintaining these flexibilities will help ensure continuity of care for patients who depend on safety-net providers for essential services. The application of MEI updates to AIR and PPS base rates is a constructive step toward maintaining payment adequacy. However, the NHC notes that MEI updates may not fully capture the real-world costs borne by RHCs and FQHCs, particularly as these providers contend with staffing shortages, inflationary pressures, and the need to invest in digital infrastructure to sustain telehealth. Additional supplemental adjustments may be necessary to prevent financial instability. The expansion of billable behavioral health services to include MFTs and MHCs is a positive development that will expand the workforce available to provide care in safety-net settings. Nevertheless, significant challenges remain in recruiting and retaining behavioral health professionals in rural and underserved communities. Without concurrent investment in workforce development and support programs, coverage expansions alone may be insufficient to meet patient demand. Finally, the NHC notes that administrative burden remains a significant obstacle for RHCs and FQHCs, many of which operate with limited administrative staff. Reporting requirements that vary across Medicare, Medicaid, and other federal or state programs create inefficiencies that divert resources away from patient care.

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[54] NHC, “NHC Comments on CY 2024 PFS Proposed Rule.”

[55] NHC, “NHC Comments on CY 2024 PFS Proposed Rule.”

[56] National Rural Health Association, "National Rural Health Association Policy Brief," accessed August 29, 2025, https://www.ruralhealth.us/nationalruralhealth/media/documents/nrha-impact-of-telehealth-policy-on-rural-health-access-2024.pdf.

The NHC recommends that CMS closely monitor the utilization and outcomes of telehealth services in RHCs and FQHCs, with particular attention to differences in access across geographic regions and beneficiary populations. The agency should also evaluate the adequacy of AIR and PPS base rates under the MEI methodology and consider supplemental adjustments where necessary to support the long-term sustainability of these safety-net providers. To support the expansion of behavioral health services, CMS should coordinate with other federal agencies to invest in workforce development programs that address shortages in rural and underserved areas. The agency should also prioritize efforts to streamline reporting requirements across Medicare and Medicaid to reduce unnecessary administrative burden and enable providers to focus on patient care. Finally, CMS should ensure that patient and caregiver voices are incorporated into the evaluation of telehealth and behavioral health integration policies in RHCs and FQHCs, to guarantee that reforms remain responsive to the needs of the communities these providers serve.

Quality Payment Program (QPP) and Promoting Interoperability (PI)

For CY 2026, CMS proposes several updates to the QPP and PI requirements. These include the creation of new Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) in endocrinology, infectious disease, and emergency medicine, expanding opportunities for clinicians to participate in more targeted, specialty-specific frameworks. CMS also proposes to raise the MIPS performance threshold from 75 to 80 points, citing expectations of higher baseline performance. With respect to Advanced APMs, CMS offers clarifications on Qualifying Participant (QP) determinations and the use of the All-Payer Option, intended to improve transparency and consistency for clinicians participating in multi-payer models. CMS further proposes updates to PI requirements, including new objectives for data collection and technical updates to application programming interfaces (APIs) to facilitate more seamless data exchange.

The NHC has consistently supported the integration of PROMs into quality reporting, along with policies that reduce participation burdens for small practices and those with limited resources. The NHC has emphasized that the long-term success of QPP depends not only on methodological rigor but also on the practicality of implementation across diverse practice environments and on ensuring that measures reflect outcomes and experiences meaningful to patients and caregivers.[57] The addition of new MVPs for endocrinology, infectious disease, and emergency medicine represents a constructive step toward ensuring that specialists have access to performance frameworks relevant to their clinical work. At the same time, the NHC underscores the importance of embedding structured patient input into MVP development to ensure that quality measures reflect what matters most to patients. The proposed increase in the MIPS performance threshold raises concerns about the ability of small, rural, and resource-constrained practices to keep pace. While higher thresholds may encourage performance gains in some settings, they may also discourage participation among providers with limited administrative or technical capacity. A phased approach to raising the threshold would provide additional time for practices to adapt, reducing the risk of participation drop-off. The proposed PI updates, particularly the expansion of required

[57] NHC, “NHC Comments on CY 2025 PFS Proposed Rule.”

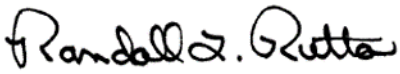
data capture and the modernization of APIs, have the potential to improve care coordination and clinical decision-making. However, these updates must be paired with appropriate tools, training, and safeguards to protect patients and minimize burden. Without adequate support, practices with limited resources may find it challenging to comply, undermining the intended benefits of the program.

The NHC recommends that CMS phase in the proposed MIPS threshold increase, embed patient engagement in MVP design, and ensure that data reporting requirements are standardized and streamlined. CMS should provide targeted technical assistance and financial support to smaller and rural practices to facilitate adoption of new requirements. Finally, the agency should simplify the rules governing the All-Payer Option to promote broader participation and alignment across payers.

Conclusion

Thank you for the opportunity to provide feedback on the CY 2026 PFS proposed rule. The NHC stands ready to collaborate with CMS to ensure these policies advance payment stability, patient access, and improved outcomes for people living with chronic diseases and disabilities. Please do not hesitate to contact Kimberly Beer, Senior Vice President, Policy & External Affairs, at kbeer@nhcouncil.org, or Shion Chang, Senior Director, Policy & Regulatory Affairs, at schang@nhcouncil.org, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



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